January 2016

Promoting Patient-Centered Team-Based Care: An Advocacy Toolkit

Michelle Schmerge
michelle.schmerge@yale.edu

Promoting Patient-Centered Team-Based Care: An Advocacy Toolkit

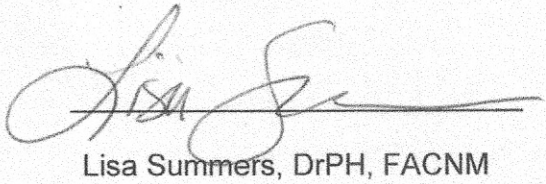
Submitted to the Faculty
Yale University School of Nursing

In Partial Fulfillment
of the Requirements for the Degree
Doctor of Nursing Practice

Michelle Schmerge, ANP-BC, MSN, RN

May 22, 2017

This capstone is accepted in partial fulfillment of the requirements for the degree Doctor of Nursing Practice.



Lisa Summers, DrPH, FACNM

Date here 2-28-2017

Signed: 

February 28, 2017

Promoting Patient-Centered Team-Based Care: An Advocacy Toolkit

Michelle Schmerge, ANP-BC, MSN, RN

Advisor: Lisa Summers, DrPH, FACNM

Committee Members: Janet Haebler, MSN, RN and Ruth McCorkle, PhD

Yale University School of Nursing

November 29, 2016

Abstract

The high performing patient care team is now widely recognized as an essential model for constructing a more patient-centered, coordinated, and effective system of health care delivery. In order to achieve these goals, health care teams need diverse members with flexible leadership. Unfortunately, too many members of the health care team are burdened by unnecessary supervision requirements, and efforts to reform scope of practice laws have met with resistance from organized medicine. In 2014, the American Medical Association (AMA) launched, "Physician-led Team Based Care", a campaign that espouses a model of team-based care where physicians oversee advanced practice registered nurse (APRN) practice, as well as all other members of the health care team. This campaign has confused the popular model of team-based health care with individual licensure authority in the legislative arena, which has prevented lifting regulatory barriers to APRN practice in some states. Furthermore, the AMA seeks to legislate the leadership, supervision, and control of the health care team. This paper describes the scholarly process of creating a toolkit that will enhance advocacy at the state level and better prepare state nursing organizations, advocates, and legislators in promoting full practice authority (FPA) for APRNs and a model of team-based health care that effectively utilizes all members of the team.

Keywords: patient care team, advanced practice nursing, health policy, scope of practice, toolkit, advocacy

Introduction

In order to provide optimal patient-centered care and effectively function in today's health care environment, health care teams need diverse members with flexible leadership. Unfortunately, too many members of the health care team, such as advanced practice registered nurses (APRNs), physician assistants, physical and occupational therapists, optometrists among others, are burdened by unnecessary supervision requirements, and efforts to reform scope of practice laws have met with resistance from organized medicine. This paper describes a scholarly Doctor of Nursing Practice (DNP) project that seeks to address this problem through the development of an advocacy toolkit.

Background

The United States spends more on health care than any other country, yet the outcomes are not representative of that investment. It is evident that the current health care infrastructure is insufficient to meet the needs of patients and health care consumers' demands today and for the future. A fundamental change in health care delivery is needed to achieve the "Triple Aim": improved quality of care, enhanced population health, and increased access to care, while reducing the costs of care (Berwick, Nolan, & Whittington, 2008). Berwick, Nolan, and Whittington devised the Triple Aim, because they felt "the remaining barriers to integrated care are not technical; they are political" (p. 759). The high-performing health care team is now widely recognized as an essential model for constructing a more patient-centered, coordinated, and effective system of health care delivery (Mitchell et al., 2012).

In an increasingly complex health care system, no single team member can perform every task that the patient needs. Health care has moved beyond just the community physician and nurse and now encompasses many health disciplines providing care to one patient. The most

important team member is the patient, but the expanded health care team can include nurses, APRNs, physicians, physician assistants, pharmacists, physical therapists, occupational therapists, speech therapists, dieticians, certified nurses aides, social workers, psychologists, and even community support systems and other allied health-disciplines.

Each of these health care team members has unique expertise and insight. APRNs offer four distinct roles with a valuable place within the health care team. Those four roles are Certified Nurse Practitioner (CNP), Certified Nurse Midwife (CNM), Clinical Nurse Specialist (CNS), and Certified Registered Nurse Anesthetist (CRNA) (NCSBN, 2008). NPs practice in primary and acute care settings providing comprehensive health care across the lifespan with an emphasis on preventative care. CNMs provide primary health care to women, in addition to delivering prenatal, postpartum, and newborn care, and managing labor and delivery. CNSs provide advanced nursing care in hospitals and other clinical sites, develop quality improvement programs, and serve as mentors, researchers, and consultants. CRNAs administer anesthesia before and after surgical, therapeutic, diagnostic and obstetrical procedures, and provide acute and chronic pain management (NCSBN, 2008).

Team-based care should utilize each team member's full expert capabilities in order to deliver optimal care to patients (Mitchell et al., 2012). Although it is sometimes easy to differentiate among healthcare professionals, occasionally the lines are blurred and duties overlap. This is often the situation with physicians and APRNs. It is not realistic or cost effective to always draw distinct lines between the duties of all health care professionals.

Advanced Practice Registered Nurses

In the case of advanced practice, nurses are able to perform certain components of care that had traditionally been the province of medicine, i.e. diagnosis and pharmacotherapy. As a

result, APRNs have grown in number and visibility, and the legal and regulatory framework for nursing practice has developed and evolved. That regulatory framework acknowledges that overlapping duties between two professions does not equate to practicing the other's profession (NCSBN, 2012). "No one profession actually owns a skill or activity in and of itself. One activity does not define a profession, but it is the entire scope of activities within the practice that makes any particular profession unique. Simply because a skill or activity is within one profession's skill set does not mean another profession cannot and should not include it in its own scope of practice" (NCSBN, 2012, p. 9).

Numerous studies over the past few decades have examined the outcomes of APRNs and have demonstrated the value of APRNs in team-based care (Jesmin, Thind, & Sarma, 2012; Kahn, Hines, Woodson, & Burkham, 1977; Lipton, 2009; Proia et al., 2014; Scalley, Flegen, & Kearney, 1977; Wen & Schulman, 2014). A recent systematic review and meta-analysis found that nurses have higher scores in patient satisfaction, reduced hospital admissions, and decreased patient mortality when compared to physicians (Martínez-González et al., 2014). Additionally, cost outcomes are very important to today's health care culture and are a fundamental component of the Triple Aim in health care reform. Bauer (2010), a medical economist, concluded that APRNs provide equal if not better primary care as physicians, all at a lower cost. According to a systematic review from 2009, nurses have better outcomes when compared with physicians in the areas of care management and compliance rates. Nurses are better able to manage chronic diseases, promote disease prevention, and advocate for improved general health (Keleher, Parker, Abdulwadud, & Francis, 2009). Furthermore, APRNs often spend more time on patient consultations, which contributes to the satisfaction of patients with their care (Shum et al., 2000; Venning, Durie, Roland, Roberts, & Leese, 2000).

Legal and Regularly Barriers to APRN practice

A major barrier to team-based health care is regulatory restrictions on the practice of some members of the team. For the past few years, in an effort to avoid misunderstanding with the use of controversial terms like "independent practice," APRN groups have used the term full practice authority (FPA). The American Association of Nurse Practitioners (AANP) defines "full practice authority as "the collection of state practice and licensure laws that allow for nurse practitioners to evaluate patients, diagnose, order and interpret diagnostic tests, initiate and manage treatments—including prescribe medications—under the exclusive licensure authority of the of the state board of nursing" (2013, p. 1). In short, FPA would allow APRNs to practice to the full extent of their education and training. While APRNs have FPA in twenty-one states and the District of Columbia, some states are still holding on to burdensome regulations and legislation that limit APRN practice (ANA, 2015a). For example, some states require physician supervision of APRN practice, which typically includes a collaborative practice agreement, and a biannual meeting to discuss a case, but little to no actual supervision (AANP, 2014). This patchwork of state laws with varying degrees of restrictions leaves some APRNs unable to function at the highest level of their abilities and limits their mobility from state to state.

APRNs have been working to lift these barriers in order to provide better access to care and promote their role in the health care team, and those efforts have been supported by a growing number of allies. The Institute of Medicine (IOM) in its 2010 report *The Future of Nursing: Focus on Scope of Practice* states:

> While challenges face nurses at all levels, the committee took particular note of the legal barriers in many states that prohibit advance practice registered nurses (APRNs) from practicing to their full education and training. The committee

> determined that such constraints will have to be lifted in order for nurses to assume the responsibilities they can and should be taking during this time of great need. (p. 1)

Echoing the call for enhanced access to care, the Veteran's Health Association (VHA), the National Governors Association (NGA), and the Federal Trade Commission (FTC), the American Association of Retired Persons (AARP) and the National Association of Community Health Centers (NACHC) have all issued statements advocating for lifting barriers to APRN practice (ANA, 2015b).

Defining Team-Based Health Care

The IOM's discussion paper, "Core Principles & Values of Effective Team-Based Health Care," provides an important foundation for examining the value of team-based care. Team based care is defined as:

> Team-Based health care is the provision of health services to individuals, families, and/or communities by at least two healthcare providers who work collaboratively with patients and their caregivers—to the extent preferred by each patient—to accomplish shared goals within and across settings to achieve coordinated high-quality care. (Mitchell et al., 2012, p. 5)

In addition to the definition, Mitchell et al. (2012) highlight specific values and principles upon which highly functioning teams are founded: honesty, discipline, creativity, humility, and curiosity. Honesty helps foster effective communication and trust among team members where their efforts are transparent and areas for improvement are discussed and adopted. Team members must be disciplined to adhere to their specific roles, scope of practice, and protocols in order to carry out their jobs effectively, even when it is inconvenient or uncomfortable.

Creativity and curiosity are paramount in team-based care allowing team members to seek out new ways of solving problems, learn from poor outcomes, and commit to continual improvement of the team's practice. Finally, and perhaps most importantly, team members need to maintain humility by accepting and celebrating the roles of the various other health care disciplines. Humility in health care teams demands that one team member does not fundamentally believe that he or she is superior to another. All team members will make mistakes and team members must view such mistakes as opportunities for improvement. One team member cannot do everything, and when providers work together in a team, outcomes are much improved over the work over just one person (Mitchell et al., 2012). Furthermore, in the current health care system, there are numerous health care providers with the ability to perform the same tasks; and therefore, some roles are interchangeable.

Mitchell et al. (2012) go further to describe five core principles upon which team-based health care is founded: shared goals, clear roles, mutual trust, effective communication, and measureable processes and outcomes. The team, which includes the patient and/or families, should meet initially and regularly to establish goals of care. The team should ensure that all team members understand the goals of care as well as accept the evolution of those goals throughout the care process and patient's lifespan. It is important to clearly define the roles of each team member and build on each team member's strengths. Team members should be accountable and responsible for their own roles and capitalize on dividing tasks to be more efficient and avoid waste. Mutual trust is critical to the success of the team so that the team may take advantage of reciprocity and achievements become communal. Effective communication among team members is paramount to success and must be developed and readily accessible no matter the setting and physical distance between each other. Finally, processes and outcomes

defined by the team must be measurable to provide feedback and facilitate improvement of the team (Mitchell et al., 2012).

Leadership in Team-Based Health Care

Health care teams naturally need leadership. Leadership within the team needs to be fluid, evolving and adapting over time for a given situation. While patients should have a central role in directing their own care, leadership among the other members of the health care team should be defined. The American College of Cardiology recently tackled the subject of leadership in their *2015 ACC Health Policy Statement on Cardiovascular Team-Based Care and the Role of Advanced Practice Providers*:

> Front-line practitioners usually have no trouble figuring out who is the logical leader of the team. Leadership of healthcare teams can be situational, clinical, or managerial, depending on the charge and the task that the team is undertaking.... It is our position that leadership should be flexible, reflecting the special needs of the patient at a particular time and setting. For example, a chaplain or a social worker may lead a team meeting to discuss transition to palliative care; a nurse or a pharmacist may lead a team that organizes a chronic anticoagulation clinic; and an APRN or PA may lead a team that coordinates transitions of care. The leader should be the team member with the greatest knowledge and experience and the best qualifications for the leadership task at hand. (Brush, Jr. et al., 2015, p. 2123)

Leadership of health care teams should be flexible and situational. Team leaders should be selected based on the unique expertise and experience of the qualified health professional.

The current controversy on the leadership of health care teams is rooted in scope of practice laws. Scope of practice is a legal term referring to the activities a health care

professional is allowed to perform in a given state. Almost all members of the health care team are unnecessarily restricted in practice as a result of scope of practice laws. There is, however, one exception: physicians.

Physicians have the oldest and most broad scope of practice laws. Many other health professionals have scope of practice laws that are "carved out" of the practice of physicians, with many states' laws requiring that physicians must supervise the practice of these health care professionals (Safriet, 2002, p. 308). The literature simply does not support this notion. There is a substantial body of evidence supporting safe, quality, and cost effective health care when delivered by APRNs (Martínez-González et al., 2014).

There are several problems inherent to physician supervision of APRNs. Many APRNs are required to pay a fee to a collaborating or supervising physician. In exchange, the physician signs a collaborative practice agreement, but there is little to no supervision or even collaboration taking place. Furthermore, this arrangement often results in increased health care costs, duplication of services, and exacerbation of provider shortages, without proving a benefit to the patient (ANA, 2015a).

In 2012, representatives of six national health care organizations collaborated on a document intended to help legislators decide when a profession's scope of practice should be modified (NCSBN, 2012). The six health care regulatory organizations participating were the Association of Social Work Boards (ASWB), the Federation of State Boards of Physical Therapy (FSBPT), the Federation of State Medical Boards of the United States, Inc. (FSMB), the National Association of Boards of Pharmacy (NABP), the National Board for Certification in Occupational Therapy, Inc. (NBCOT), and the National Council of State Boards of Nursing, Inc (NCSBN). The document emphasizes that scope of practice laws are meant to protect the public.

They state, "The argument for scope of practice changes should have a foundational basis within four areas: 1) an established history of the practice scope within the profession, 2) education and training, 3) supporting evidence, and 4) appropriate regulatory environment" (NCSBN, 2012, p3). When a profession can speak to these four areas and provide evidence within each of them, scope of practice amendment is "in the public's best interest" (NCSBN, 2012, p. 3).

Government regulation's sole purpose is to protect the public and this should guide scope of practice reform, not safeguard the self-interests of professional groups. Scope of practice reform is necessary as a profession's practice evolves. Many things contribute to the evolution of a profession such as technology, patient demographics, and evidence-based advancement in the practice of medicine, among others. Changes in a profession's scope of practice should not result in independent practice. Collaboration among health care providers is not only encouraged; it is essential to effectively practice in today's healthcare environment. Collaboration should be enhanced with reformed scope of practice, not the opposite. Changes in scope of practice laws will likely result in overlap in activities and skills provided by multiple professions. This is not a negative result of scope of practice reform. This overlap of practice is necessary, inevitable, and vital to promoting optimal patient care (NCSBN, 2012).

The Problem

While many organizations and individual physicians have embraced the APRN role, it has not been without controversy. Unfortunately, organized medicine has resisted legal and regulatory changes when their practice is encroached upon. These physician groups have accepted nurses as members of teams, but are very resistant to nursing *leadership* of health care teams. The control and supervision of the team is at the heart of the debate.

In 2014, the American Medical Association launched, "Physician-led Team Based Care" (AMA, 2014), a campaign that espouses a model of team-based care where physicians oversee APRN practice, as well as all other members of the health care team. They state, "Physicians bring to the team the highest level of training and preparation and as such are the best suited to guide the other members of the team" (AMA, 2014, p. 3). This stance prohibits effective teamwork because one member of the team has announced his or her superiority to other team members. The AMA reports that all members of the health care team (e.g., nurses, APRNs, physical and occupational therapists, pharmacists, dieticians, etc.) lack enough education and training to lead the team and must be supervised by a physician (AMA, 2014). This stance prevents qualified members of the team from delivering health care to their full abilities, it takes away from valuable time dedicated to direct patient care, and it serves as a barrier to high functioning health care teams. It is also not realistic to proclaim one team member as all time team-leader. This is a poor use of resources and health care dollars.

Despite overwhelming support for APRN FPA, the AMA campaign has been effective at preventing states from adopting FPA legislation. This campaign is essentially a Trojan horse; using the popular "team based care" language to describe legislation that would, in fact, severely limit APRN practice.

One recent extreme example of this campaign is found in Tennessee, where the Tennessee Medial Association introduced the "Tennessee Healthcare Improvement Act of 2015." The bill actually spelled out health care conditions that could not be managed by APRNs, including "complex conditions" such as being under the age of 12, pregnancy, and chronic pain. The bill was not passed, but was incredibly effective at stalling FPA legislation. One problem with utilizing physician-led team-based care is that we are already using this model in many

states and it has not proved to be the solution to poor access to care, high costs, and inadequate value of health care.

Purpose

The purpose of this DNP project is to create an advocacy toolkit that will assist the ANA and organized nursing's advocacy efforts to oppose organized medicine's "Physician-led Team Based Care" campaign. In order to achieve FPA in all states, advocacy efforts by state nursing organizations need to be streamlined and improved. A compilation of materials and tools promoting patient-centered team-based health care were developed, which could greatly enhance the FPA initiative. These tools will be utilized at the state level and it is the intention of the project for the tools to be edited and adapted to the individual needs of advocates within state nursing organizations.

Objective/Aims

The overarching goal of the capstone is to facilitate advocacy efforts for FPA legislation by creating an advocacy toolkit promoting team-based health care.

Specific Aims:

1. To review the literature on team based care and scope of practice for APRNs.
2. To describe the need for team-based care and the barriers to implement team based-care, i.e. scope of practice regulations on APRNs.
3. To conduct key informant interviews to identify gaps in knowledge for advocates.
4. To create a team-based health care toolkit that will maximize advocacy efforts of ANA members in the states.

Methodology

The methods to be utilized to achieve the four aims of the capstone project are outlined below.

Aim 1: To review the literature on team-based care. SCOPUS database was searched for articles with the following terms in their titles: "Team Based Health Care," "Health Care Teams" "Care Coordination," "Coordinating Care," "Patient Centered Care Team," and "Patient Centered Care." A comprehensive review of reference lists were evaluated and select articles were included if they met inclusion criteria. Articles were included in the literature review if they pertained to advanced practice registered nurses or health care professionals. For the evidence based literature review, articles were included if they had the terms "team based health care," "health care teams," or "care coordination" in the title or were referenced in the 2012 IOM discussion paper *Core Principles & Values of Effective Team-Based Health Care*. Of particular interest were studies that reported on outcomes of team-based health care approaches. Articles were excluded if they were about interdisciplinary educational initiatives or interdisciplinary education. Additionally, articles were excluded if they were about specific models of team-based care. For the scope of practice literature review, SCOPUS database was also searched for articles pertaining to "scope of practice" literature. Articles were excluded if they did not address nursing's scope of practice.

Inclusion Criteria:

Language: English only text

Terms: Team Based Health Care, Health Care Teams, Care Coordination, Coordinating Care, Patient Centered Care Team, Patient Centered Care, Multidisciplinary Health Care, Interdisciplinary Care, Multiprofessional Health Care, and Interprofessional Health Care, APRN Scope of Practice, Health Care Professionals' Scope of Practice

Study Designs: Included all study designs, as well as IOM discussion paper

Publication years: 1970 to present

Population: advanced practice registered nurses, health care professionals

Outcomes: patient perception of care, patient satisfaction, quality of care, access to care, costs of care, care coordination

Exclusion Criteria:

Language: Non-English Text

Publication years: Those prior to 1970

Themes: Multidisciplinary Educational Programs, Interdisciplinary Educational Programs, Team-based health care models; Non-nursing Scope of Practice

Outcomes: Those not appropriate to subject matter

Aim 2: To describe the need for team-based care and the barriers to implement team-based care, i.e. scope of practice regulations on APRNs. In accordance with the IOM discussion paper "Core Principles & Values of Effective Team-Based Health Care," team-based health care was outlined and its benefit described. Additionally, in those states where scope of practice is restricted, laws and regulations were reviewed and helped guide the development of the toolkit. Finally, a comprehensive analysis of the AMA's "Physician-led Team-Based Care" messaging informed the project.

Aim 3: To conduct key informant interviews to identify gaps in knowledge for advocates. Over the course of several months, key informant interviews were conducted. Key informants were comprised of nursing policy leaders and executive directors of state nursing associations. The goal of the key informant interviews was to determine the need and usefulness of the advocacy toolkit and improve existing toolkit components. All key informants were asked the same questions:

1. Do you think the team-based health care toolkit would be useful?

2. Would you use the toolkit?
3. Could you give feedback on the existing documents?
4. What is missing from the toolkit?
5. Who else should be a key informant?
6. Would you be willing to read and give feedback on the team-based care issue brief?

The answers to these questions informed the project and facilitated revision of existing toolkit components.

Aim 4: To create a team-based health care toolkit that will maximize advocacy efforts of ANA members in the states. With the help of the project advisor, committee members, and key informants, a toolkit on team-based health care was created for advocacy purposes. The goal was to provide legislators who were hearing about "physician-led care" an alternative message of team-based health care. Given the diversity of the states, it is difficult to create tools at the national level for use in the states. The toolkit was created at the national level and branded by the ANA, but depended heavily on the input of key informants in the states. The intention was to create components of the toolkit that could be adapted by state nursing associations and nursing advocates for use at the state level.

Description of the Toolkit

The components of the toolkit are outlined below. Throughout the development and dissemination of the toolkit, advice and feedback was sought. Specific elements of the toolkit are expected to further evolve.

Toolkit Contents:

Issue Brief – "Promoting Patient-Centered Team Based Care" – The issue brief outlines the Institute of Medicine's discussion paper on team-based health care and provides recommendations for fostering unencumbered health care team.

Executive Summary – Provides three key messages and is a simplified one-page version of the issue brief.

Conducting a Political Environmental Scan – This document outlines crucial elements for nursing leaders and advocates to consider when developing/executing strategy(s) to advance legislation or regulation (ANA, 2013).

Words Matter – A guide to discussing APRN practice and tips for messaging (ANA, 2015c).

Principles for Full Practice Authority – Provides policy makers and stakeholders with evidence-based guidance when considering changes in statute or regulation for APRNs (ANA, 2015a).

Policy Makers on the Effective Utilization of APRNs – This document outlines what reputable groups report about the need for APRN Full Practice Authority (ANA, 2015b).

Infographic – A pictorial description of the four APRN roles was created and includes information on their licensure, education, and certification.

APRN Consensus Model Toolkit – A series of resources compiled by the ANA designed to help stakeholders better understand the Consensus Model for APRN Regulation (ANA, 2016). The consensus model defines APRNs and describes foundational requirements of a regulatory model for each of the four APRN roles: licensure, accreditation, certification, and education (NCSBN, 2008).

Team-Based Care: A Case Study from Tennessee – Exemplifies one state medical society's efforts to restrict APRN practice.

Plan/Dissemination

The implications of the project are extremely important for the nursing community. The AMA has been successful at halting state nursing organizations' initiatives for advancing FPA legislation. The toolkit created as a result of this project will enhance advocacy at the state level and better prepare state nursing organizations, advocates, and legislators in promoting a model of team-based health care that effectively utilizes all members of the team. Better prepared advocates and stakeholders could result in passage of full-practice authority legislation in more states.

The toolkit has been published on the ANA website, and it was presented at the ANA Lobbyist Meeting and on the monthly Center to Champion Nursing in American (CCNA) Removing Barriers to Practice conference call. The ongoing plan is to monitor its use in the upcoming legislative session and to edit the materials in accordance with feedback.

The toolkit can be found at:

http://www.nursingworld.org/EspeciallyForYou/AdvancedPracticeNurses/Scope-of-Practice-2/Team-Based-Care

References

American Association of Nurse Practitioners [AANP]. (2013). Issues At-A-Glance: Full Practice Authority. Retrieved November 16, 2016 from http://c.ymcdn.com/sites/www.npamonline.org/resource/resmgr/imported/Full%20practice%20authority.pdf

American Association of Nurse Practitioners [AANP]. (2014). State practice environment. Retrieved November 26, 2014 from http://www.aanp.org/legislation-regulation/state-legislation-regulation/state-practice-environment

American Medical Association [AMA]. (2014). AMA Advocacy Resource Center: Physician-led health care teams. Retrieved on September 18, 2015 from ama-assn.org/go/physicianledteams

American Nurses Association [ANA]. (2013). Conducting a Political Environmental Scan. Retrieved on January 27, 2016 from http://www.nursingworld.org/MainMenuCategories/Policy-Advocacy/AdvocacyResourcesTools/ConductingPoliticalEnvironmentalScan.pdf

American Nurses Association [ANA]. (2015a). ANA's principles for advanced practice registered nurse (APRN) full practice authority. Retrieved on December 3, 2015 from http://www.nursingworld.org/MainMenuCategories/ThePracticeofProfessionalNursing/NursingStandards/ANAPrinciples/Principles-for-APRN-Full-Practice-Authority.pdf

American Nurses Association [ANA]. (2015b). Policy makers on the effective utilization of advanced practice registered nurses (APRNs). Retrieved on September 20, 2015 from

http://www.nursingworld.org/MainMenuCategories/Policy-Advocacy/State/Legislative-Agenda-Reports/APRN/Policy-Makers-on-the-Effective-Utilization-of-APRNs.pdf

American Nurses Association [ANA]. (2015c). Words matter—Guide to discussing APRN practice. Retrieved on September 20, 2015 from http://www.nursingworld.org/WordsMatter

American Nurses Association [ANA]. (2016). APRN Consensus Model Toolkit. Retrieved on November 27, 2016 from http://www.nursingworld.org/consensusmodel

Bauer, J. C. (2010). Nurse practitioners as an underutilized resource for health reform: Evidence-based demonstrations of cost-effectiveness. *Journal of the American Academy of Nurse Practitioners, 22*, 228-231. doi:http://dx.doi.org/10.1111/j.1745-7599.2010.00498.x

Berwick, D. M., Nolan, T. W., & Whittington, J. (2008). The Triple Aim: Care, Health, and Cost. *Health Affairs*, 27, 759-769.

Brush, J. E., Handberg, E. M., Biga, C., Birtcher, K. K., Bove, A. A., Casale, P. N., . . . Wyman, J. F. (2015). 2015 ACC health policy statement on cardiovascular team-based care and the role of advanced practice providers. *Journal of the American College of Cardiology, 65*, 2118-2136. doi:10.1016/j.jacc.2015.03.550

Institute of Medicine [IOM]. (2010a). *The Future of Nursing: Leading Change, Advancing Health.* Retrieved September 3, 2014 from http://www.iom.edu/Reports/2010/The-future-of-nursing-leading-change-advancing-health.aspx

Institute of Medicine [IOM]. (2010b). *The Future of Nursing: Focus on Scope of Practice.* Retrieved November 16, 2016 from

http://www.nationalacademies.org/hmd/~/media/Files/Report%20Files/2010/The-Future-of-Nursing/Nursing%20Scope%20of%20Practice%202010%20Brief.pdf

Jesmin, S., Thind, A., & Sarma, S. (2012). Does team-based primary health care improve patients' perception of outcomes? Evidence from the 2007-08 Canadian survey of experiences with primary health. *Health Policy, 105*, 71-83. doi:10.1016/j.healthpol.2012.01.008

Kahn, K. A., Hines, W., Woodson, A. S., & Burkham Armstrong, G. (1977). A multidisciplinary approach to assessing the quality of care in long term care facilities. *Gerontologist, 17*, 61-65. Retrieved from SCOPUS database.

Keleher, H., Parker, R., Abdulwadud, O., & Francis, K. (2009). Systematic review of the effectiveness of primary care nursing. *International Journal of Nursing Practice, 15*, 16-24. doi:10.1111/j.1440-172X.2008.01726.x

Lipton, H. L. (2009). Home is where the health is: Advancing team-based care in chronic disease management. *Archives of Internal Medicine, 169*, 1945-1948. doi:10.1001/archinternmed.2009.428

Martínez-González, N. A., Djalali, S., Tandjung, R., Huber-Geismann, F., Markun, S., Wensing, M., & Rosemann, T. (2014). Substitution of physicians by nurses in primary care: A systematic review and meta-analysis. *BMC Health Services Research, 14* doi:10.1186/1472-6963-14-214

Mitchell, P., Wynia, M., Golden, R., McNeellis, B., Okun, S., Webb, C. E., ...Kohorn, I. V. (2012). Core principles & values of effective team-based health care. Discussion Paper,

Institute of Medicine, Washington, DC. Retrieved on September 18, 2015 from www.iom.edu/tbc

National Council of State Boards of Nursing. (2008). Consensus model for APRN regulation: Licensure, accreditation, certification & education. Retrieved on September 20, 2015 from https://www.ncsbn.org/Consensus_Model_for_APRN_Regulation_July_2008.pdf

National Council of State Boards of Nursing. (2012). Changes in Healthcare Professions' Scope of Practice: legislative considerations. Retrieved on September 19, 2015 from https://www.ncsbn.org/ScopeofPractice_09.pdf

Proia, K. K., Thota, A. B., Njie, G. J., Finnie, R. K. C., Hopkins, D. P., Mukhtar, Q., . . . Cooksey, T. (2014). Team-based care and improved blood pressure control: A community guide systematic review. *American Journal of Preventive Medicine, 47*, 86-99. doi:10.1016/j.amepre.2014.03.004

Safriet, B. J. (2002). Closing the gap between can and may in health-care providers' scope of practice: A primer for policy makers. *Faculty Scholarship Series.* Retrieved from http://digital commons.law.yale.edu/fss_papers/4422

Scalley, R. D., Flegen, K., & Kearney, E. (1977). Interdisciplinary diabetic team in a community hospital. *American Journal of Hospital Pharmacy, 34*, 1245-1248. Retrieved from SCOPUS database.

Shum, C., Humphreys, A., Wheeler, D., Cochrane, M., Skoda, S., & Clement, S. (2000). Nurse management of patients with minor illnesses in general practice: Multicentre, randomised

controlled trial. *British Medical Journal, 320*, 1038-1043. Retrieved from SCOPUS database.

Tennessee Healthcare Improvement Act of 2015, House Bill 861, Senate Bill 521. (2015). Retrieved on December 4, 2015 from http://www.capitol.tn.gov/Bills/109/Bill/HB0861.pdf

Venning, P., Durie, A., Roland, M., Roberts, C., & Leese, B. (2000). Randomised controlled trial comparing cost effectiveness of general practitioners and nurse practitioners in primary care. *British Medical Journal, 320*, 1048-1053. Retrieved from SCOPUS database.

Wen, J., & Schulman, K. A. (2014). Can team-based care improve patient satisfaction? A systematic review of randomized controlled trials. *Plos One, 9* doi:10.1371/journal.pone.0100603